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Dr. Shankara Chetty: Severe Covid Illness Is Due to An Allergic Reaction to The Spike Protein

Rhoda Wilson : 58-74 minutes : 2/22/2022

Breaking News

Dr. Shankara Chetty gave his testimony on Day 3 of the Grand Jury Proceeding by the Peoples' Court of Public Opinion. He described the research he has conducted regarding Covid. His research concludes that severe illness caused by SARS-CoV-2 is in fact an allergic reaction to the spike protein. He also describes the treatment protocol he has been using on his patients with 100% success rate.

Dr. Chetty is a medical practitioner in South Africa who has a background in genetics, advanced biology, microbiology and biochemistry. And so, "I investigate everything, and I make sure that I fall back on the knowledge I've gained in those years of tertiary education and don't really believe things too easily ... with the controversy around hydroxychloroquine, with the PCR test being used as a diagnostic tool, with the word that there is asymptomatic spread, I had a very healthy suspicion for what I was being told. So, with the knowledge that I had, I decided that I'm going to take this [Covid] on," Dr. Chetty said.

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"I needed to get myself a toolbox in preparation for this. So, when I looked at this, we're dealing with the respiratory virus. The first drug that came to mind was hydroxychloroquine. Hydroxychloroquine or plasmoguin is well known. It's been used for decades, and it has broad antiviral effect. So, if I had to look at something that will curtail the spread of a virus, I would look at that as my mainstay treatment.

"I bought up as much stock of hydroxychloroquine as I could, and subsequently, two days after I did that, the government here in South Africa pulled it from the shelves. Luckily, I had stock of it, and I had prepared for my patients.

"Patients came to see me very distraught that I might close and I might not be available to them. But I reassured all of them that I would brave this out, and I would make sure that I examine every one of them and I needed to understand what we're actually dealing with."

During the first wave, he noticed that for a small subset of patients, on the eighth day, precisely the eighth day, after symptoms, for example, a sore throat first appeared, patients would become breathless. He realised he was dealing with two pathologies; the two phases of illness had no correlation between them. He worked out that the second pathology, the eighth day illness, was an allergic reaction to the spike protein. So, this is how he treated his patients, as he treats any allergic reaction.

This eighth day allergic reaction, although the symptoms presented differently in each phase, was repeated in the second and third waves. In each of the waves he treated the second phase of illness, those few who developed signs of an allergic reaction on the eighth day, as an allergic reaction.

"They've refused to accept my work on the pathogenesis of Covid illness. I think simply because I have proven that spike protein is the primary pathogen. And if you accept that spike protein is the primary pathogen, that shows the vaccines in a very dangerous light. If you don't accept what causes severe illness and death, how can you claim that your product [vaccine] can prevent it? We know that it's not a vaccine because it doesn't prevent infection and transmission. Now, it exposes you to spike protein. So clearly, if you're allergic to spike protein, the vaccine works as a desensitisation tool," Dr. Chetty said.

He also noticed that different variants affected different ethnicities. The first wave affected black people only. The second wave affected those of Indian descent only. And the third, omicron, affected white and those of Arab descent only. "Then I looked at the world around me and I found exactly the same happened in America," he said.

"So that drew my attention to something far more sinister. I knew that I was dealing with an engineered virus ... Because if this was pre-planned, then it's a preamble to ethnic cleansing. It's an understanding of how to affect different systems and how to affect different population groups with the mutations that you engineer into a virus. And so, I knew at that point that I'm probably dealing with the bioweapon."

Dr. Chetty has treated 10,000 patients, "I have not had a single death. I have not hospitalised a single patient, and I have not put a single patient on oxygen," Dr. Chetty testified.

Below is the video of Dr. Chetty's testimony and the transcript.

Click on the image below to watch the [video on Bitchute](#).

Grand Jury Day 3: Dr. Shankara Chetty Testimony, 13 February 2022 (77 mins)

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Transcript Dr. Shankara Chetty

Reiner Fuellmich: Now for the good news. There is good news in this. Dr. Shankara Chetty will tell us about this, because as we have learnt, this is an illusion. We're not dealing with a Corona pandemic, but we're dealing with a PCR test pandemic. And there are ways of treating this virus, which, as the numbers tell us, is no more dangerous than the common flu. Dr. Chetty, what good news can you tell us?

Dr. Shankara Chetty: Thank you, Reiner, and thank you to all my colleagues on this platform. This has been a two-year heart wrenching journey, and I think that we're doing very important work.

I think that an understanding of what I've been through in these two years will bring understanding to what the people before me had presented and understanding to what actually has transpired. And so, I think just a narration of my journey and my understanding of this pandemic can lend a lot to what we are trying to achieve.

So, before I start, I'd like to start with what transpired before Covid came to South Africa in the first place.

I have a background in genetics, in advanced biology, in microbiology, and in biochemistry, besides my general practitioner medical work. And so, I'm a very suspicious doctor. I investigate everything, and I make sure that I fall back on the knowledge I've gained in those years of tertiary education and don't really believe things too easily.

So, before this pandemic came to South Africa, we were told that there was a virus in Wuhan and it had spread from person to person. It was a respiratory virus, seemed to be highly infectious. And of course, with the new virus, we had no understanding of how it killed, how it caused severe illness and death. But we were told it's highly contagious, and it could be the start of a new pandemic.

The first thing that I found very strange was that the Chinese cordoned off Wuhan and the virus never spread to any other city in that country, yet their international borders were left open and it spread around the globe. So that was the first thing I found very suspicious. We're dealing with a highly contagious virus. Why wasn't it completely contained?

And of course, we weren't getting very much information from China, which is what I expected. Now, as a doctor, I needed to plan. When this virus got to my country, I needed to be ready for it.

The first thing I noticed that was problematic was this PCR test. They had developed a PCR test to test for the virus itself. Now, with my scientific background, I'm well aware that a PCR test is never used as a diagnostic tool. And so, I wondered why this became a norm.

As well, we started getting reports of asymptomatic spread never before heard in medical science. So, there were these unusual things coming out.

And of course, a PCR test has absolutely no bearing on infectiousness as the previous people that submitted have alluded to. A PCR test just tests fragments of the virus. It does not test for an infectious complete agent. And it does not tell whether someone is actually infected or infectious. The only thing that tells you that a virus exists is a culture, a cell culture of the virus that proves that the virus can grow, replicate, and spread. So, I looked at this PCR test with a little bit of suspicion. And then this PCR test was being used to gauge or to determine public health measures. And the public health measures were sanitation.

And, of course, we were getting reports that this virus was living on surfaces for five days and ten days and 15 days on different kinds of materials. And that made no sense at all. Viruses do not live that period of time. They require hosts to replicate and spread. And there is absolutely no scientific evidence of viruses living on inanimate surfaces for that length of time. So, I started to view this kind of information with a lot of suspicion.

Of course, masking came and it was controversial as well. As the doctor, I know that the masking has a limitation. And the science of it tells you that a mask will never prevent you from getting a respiratory virus. It's like putting a fence around your house and thinking you're protected from mosquitoes. The science doesn't add up. So, I started looking at all this evidence.

And then, of course, they looked at isolation measures, and they wanted people to be isolated for 14 days. So, I looked at that, and I thought, well, you want people to be isolated for 14 days, but you haven't really established how long the viral illness actually persists for – it's an arbitrary measure, 14 days. So, well, I needed to understand why that came to be, 14 days of all that we could choose. So, I had these concerns.

As well, with my history and genetics, I was aware of the gain-of-function research being done at the time. I was aware of virology and, of course, genetic warfare, manipulation of viruses. I was aware of the research being done in the Wuhan lab with coronaviruses and around spike protein well before Covid actually came to be. So, I have this background knowledge that we're dealing with a coronavirus, and it seems very strange and suspicious. And now we have a pandemic following ongoing research into coronaviruses.

So, I had a healthy suspicion that this was a lab leak. Of course, taking that a little further, it might have been an engineered virus. So, this was something that I had at the back of my mind from the start of this pandemic. And of course, the unusual things: the PCR tests; the asymptomatic spread; the sanitation measures; lockdowns; isolation, all that kind of thing made no scientific sense to me.

Now, I was faced with a population that were terrified because they were told not to seek medical attention. They were told to stay away from their doctor. And we, as doctors, were told not to treat. There's no treatment for this, and we should just do telemedicine. And if a patient deteriorated, refer them to hospital.

I'm not the kind of person to capitulate that easily. So, with the knowledge that I had, I decided that I'm going to take this on. We needed information about this illness, and without that information – about the pathology of this illness – we'll never solved the problem.

Now, I knew once the virus got to Italy, that I would get some information about its symptoms. And the things that came out that were unusual, that would allow me to diagnose this without having to use a PCR test, because as doctors, we should diagnose illnesses symptomatically. And so, the symptoms that are unique to an illness will give you an indication that you're dealing with that kind of illness.

And the symptoms that I found unusual were the loss of smell and taste, which doesn't routinely occur with respiratory viruses, and of course, the breathlessness that people were presenting with. And this breathlessness was a very sudden onset, required ventilation very quickly. So, the dyspnoea and the loss of smell and taste became my diagnostic tool to confirm whether a patient actually had a coronavirus infection or not.

And I watched. I needed to get myself a toolbox in preparation for this. So, when I looked at this, we're dealing with the respiratory virus. The first drug that came to mind was hydroxychloroquine. Hydroxychloroquine or plasmochin is well known. It's been used for decades, and it has broad antiviral effect. So, if I had to look at something that will curtail the spread of a virus, I would look at that as my mainstay treatment.

Now, hydroxychloroquine, and has been used for many other illnesses, like the treatment of rheumatoid arthritis and the rest. So, I knew that I'm dealing with a very safe drug that I could ethically give to my patients and assess its efficacy. So, I decided on getting a stock of hydroxychloroquine.

But very quickly, I noticed that, I think it was the Lancet that, published an article about the toxicity of hydroxychloroquine and its cardiac manifestations. And I thought, this is nonsense. I've been treating patients with hydroxychloroquine for many years and in higher doses in some, and I've never had a side effect with it. So, I'm a doctor that tends to use medication from Noah's Ark, because I trust the long-term efficacy and safety of those medications.

So, I bought up as much stock of hydroxychloroquine as I could, and subsequently, two days after I did that, the government here in South Africa pulled it from the shelves. So, luckily, I had stock of it, and I had prepared for my patients.

Patients came to see me very distraught that I might close and I might not be available to them. But I reassured all of them that I would brave this out, and I would make sure that I examine every one of them and I needed to understand what we're actually dealing with.

So, when the first case of coronavirus was reported in South Africa, I decided that I will fall back on my education. I moved out of my home into isolation to protect my family. My home and my practice are on the same premises. I pitched a tent, a proper clinic tent, outside my practice in the parking lot, because I trust ventilation and sunlight as the best way to protect myself from this virus. I knew that if I sanitise my hands and kept my hands away from my face, I'd be reasonably well protected. And then I could see every patient. And that was my initial plan for the pandemic.

But with the controversy around hydroxychloroquine, with the PCR test being used as a diagnostic tool, with the word that there is asymptomatic spread, I had a very healthy suspicion for what I was being told. And the so-called experts didn't seem to question this. There was no proof of all this, yet we had government experts punting this narrative.

So, I started to see patients. From the first patient that walked into my practice, I made sure I examined them. The two things that I wanted to understand was: one, the symptomatology. And of course, every patient that came in with a sudden loss of smell and taste, which is unusual, I suspected had a coronavirus infection.

So, I didn't want to do this PCR test. I didn't want to rely on this PCR test. I knew it was going to skew the numbers from the start. And I could see the worldwide pandemonium and fear that was being created.

So, when patients came to see me, I started to examine the symptoms and those that had loss of smell and taste, I assumed had coronavirus positive. I took the opportunity to test a few and only those that had loss of smell and taste, and I found them to be positive. So, I had confirmed that a loss of smell and taste was a symptom of coronavirus infection. And so, I didn't feel the need to test every patient. If a family member had loss of smell and taste, and I tested him and he was positive and the rest of the family started an illness at around the same time and presented with the same kind of symptoms, I could safely assume that they picked up the same infection, and would treat them in very much the same way.

Now, as a doctor, we are expected to come to a diagnosis with examining our patient. I was never taught to use testing as a diagnostic tool. Testing is only used if I have some confusion in my clinical diagnosis, and it is used to clarify. It is never used as a diagnostic tool. So, I do not test patients to tell me what's wrong with them. That's a bad medical practice. We don't go through years of training in clinical practice to use a swab to tell me what's wrong with the patient. So, I started to see all these patients with Covid infections.

The second thing that I was very interested in was the breathlessness. This was the thing that was causing people to die. But the first few patients that came in to see me had a common flu, a respiratory infection that looked like every other respiratory infection I had seen. They had the body aches and pains and the fever and a bit of a sore throat, and, of course, the loss of smell and taste as the unusual symptoms that drew my attention to it being a coronavirus infection.

And so, I advised every patient that came in to see me that if they had developed breathlessness, in any way or form, I would like them to report back to me immediately. Because I needed to understand exactly where this breathlessness came from and exactly why patients were ending up in hospital.

Yes, we knew in hospital that patients were breathless. The oxygen saturations were decreasing, they were being put onto ventilators. And from the information from Italy, we knew that the progression of this breathlessness could be very variable. Some patients had mild breathlessness that didn't progress and seem to resolve. Some patients had breathlessness that was a little more severe and lasted a very long time. And then, of course, there were those that developed breathlessness very suddenly, progressed very quickly, and within a day or two ended up on a ventilator. And so, I noticed that there's a strange change or difference in the speed of the progression of this breathlessness, which I needed to understand and, of course, understand how we got to that point in the first place.

So, within the first, I'd say, 20 patients that I'd seen, I got the first breathless patient come in. And of course, by educating my patients, explaining to them the gravity of what we were seeing. And of course, there was enough fear mongering in the world to make sure they presented back to me timeously. Every patient that became breathless came back to me exactly

on the day they noticed something's wrong. And I found a few things very strange, in this small subset of patients that came back to me breathless. Remember, a majority of patients recovered uneventfully, like a normal respiratory infection. They had very few chest symptoms. Most was just a sore throat that resolved in two or three days. Then they had absolutely no sequelae. So, when this happened and patients came back to me breathless, I needed to examine them and understand exactly what was happening. Now, I noticed a few very strange things.

Quite a few of these patients that presented back to me were perfectly fine the day before the breathlessness started. They have thought that they had completely recovered from the illness. There were patients that had a sore throat for a day, recovered from that sore throat, spent the rest of the week perfectly fine, engaged in sporting activities and then developed breathlessness suddenly. So, this breathlessness was a very sudden nonsense. And it seemed to always occur exactly one week after the first symptom.

So, when a patient came to me on a Monday, I questioned them. And if the sore throat started on that Monday, I documented that as the onset of symptoms. Now, we know that with viral infections, there are some viruses that run a very distinct course. They replicate for a certain number of days, your immunity kicks in, and then you eliminate that virus. So, like chickenpox and measles and those kinds of viruses, they run a specific course. They last for a specific period of time.

So, when patients came back and I noticed it was always on the eighth day, exactly one week after the onset of symptoms, I thought, well, I'm dealing with a virus that has this time frame to it. It exactly eight days later, starts to do something else. There's a new symptom presenting here, and it's not in every patient. It's in a very small subset of patients. And of course, I was seeing what I was told was happening in Italy. Some patients presented to me with a mild onset breathlessness on the eighth day and some more moderate and some very severe.

Now, part of my toolbox was hydroxychloroquine, and I reserved it for those patients in that first days that had what I thought was the high viral load. So those that had severe body aches and pains and high fevers, I would give hydroxychloroquine to. And I saw within a day or two that I'd managed to break that fever and get them on the way to recovery.

Now, every single patient that I have seen in that first phase showed signs of recovery by about the fifth or sixth day, some within a day or two, but a majority by the fifth or sixth day had signs of improvement – had their appetite back, were feeling a lot better, but that did not in any way influence what might transpire on that eighth day.

So, when I noticed this nuance that people were coming back on this vital eighth day with new symptoms, I started to educate my community about this strange nuance I was seeing. So, every patient that came to see me got interrogated. I interrogated very carefully the day they noticed that they were feeling unwell. I used that day to predict when the eighth day would be, and I would warn them of any new symptoms developing on that eighth day so that they would come back to me timeously.

The second thing I did, was I knew from Italy that we're dealing with a steroid responsive illness. And as a doctor, we know that we shouldn't be using steroids in an infection. It must be used very cautiously. It will suppress your immunity and prevent you developing a robust immune response to an infection. And if you suppress immunity, you run the risk of allowing that infection to run rampant, unchecked. So, I needed to choose a specific point in this illness where steroids would become pertinent to apply. And of course, with the eighth day, that was very obvious. That a deterioration occurred on the eighth day, and that would be the point where steroid would become appropriate. And of course, with patients showing signs of recovery before, I was pretty confident that our immunity had somehow managed to get a hold of this illness and get it into check.

So, I started patients promptly on steroids. Those that returned on the eighth day with breathlessness, were started on a course of steroids, and by the third or fourth day of steroids, they all showed good signs of recovery. Now, as a doctor, what tells me that something works is speed to recovery. Now, I don't give you a paracetamol tablet for a headache and when it takes five days to go away, assume that the paracetamol worked. Speed to recovery gives me an indication of the efficacy of my treatment. And the efficacy of my treatment and the speed to recovery gives me an indication of the underlying mechanism of this disease. So, if I'm treating the wrong thing, I won't have the speed to recovery.

So, looking at the patients that I treated from the first four or five that presented with the sleeplessness and were put on to steroids, and I noticed this difference in the presentation. That means the speed at which the second phase started. I looked at my understanding of pathology and tried to understand why we were getting this variability. The first part of the illness had no relation to the second. Whether you are critically ill in the first five days made no difference as to whether you would deteriorate again on the eighth. Because I've had patients critically ill in the first five days recovered and had no sequelae. And I've had patients with a very mild illness, got over it, and on the eighth they presented with very severe

illness. So, I knew I'm dealing with a nonlinear illness that was biphasic, and the two phases had no correlation between them. So, I was dealing with two pathologies.

So, to understand the second pathology, I had patients that were diabetic, hypertensive, a lot of co-morbidities and never had the second phase of this illness. And I had patients that were absolutely fit with no co-morbidities and had the second phase of this illness. So, it didn't seem to be related to any health pre-disposition.

So, when you look at pathology, you've got to try and understand what you're dealing with, the facts that are in front of you and what makes sense. And the only thing that made sense to me was that these people on the eighth day were having some sort of allergic reaction to something. And we know with allergic reactions that majority of people are not allergic to certain things and will have no reaction, like a bee sting. And some will be mildly allergic and some moderately allergic and some severely allergic. And so, the difference in speed of presentation and the difference in severity.

Of course, if you're mildly allergic to a bee sting, you will get a bit of an itch on the sting. And in a few days, it would be self-limiting and seem to sort itself out. However, if you were more moderately allergic, that bee sting might cause a rash throughout your body and if I do not treat it, it will take a long time for that rash to subside, though it may never end up life threatening. And then, of course, if you're very allergic to a bee sting and I don't treat you, within a day or two, you're going to end up with severe organ damage and end up in ICU and probably die from that. So, I thought, well, if I'm dealing with this kind of pathology, a type 1 mediated hypersensitivity reaction, then a therapeutic trial is in order.

Now, a therapeutic trial is something every doctor does with almost every patient. When a patient comes to see me, I have an inclination of a diagnosis, and then I give them some medication dependent on that diagnosis, which is a therapeutic trial. And if that medication that I give them shows benefit and they improve, then it confirms my diagnosis and I don't need to do anything further. I don't need to go test them to prove I was correct. They recover completely.

So, my understanding that I'm dealing with the type 1 hypersensitivity reaction drove me to improve and fine tune the toolbox that I was using. At that point in time, it was just hydroxychloroquine symptomatic treatment and, of course, steroid from day eight.

So, the sixth patient that came in to see me was a 40-year-old female who had developed breathlessness on that very day, who was, like a lot of the others, perfectly fine the day before. It was actually her eighth day of illness, and her saturations had dropped to 80% in that one day. Yesterday, she was fine. She, being diabetic, hypertensive and obese, I was a bit concerned. But I knew I had to start a steroid. But I'm dealing with a particular ill patient. So, I thought, well, if this is an allergic reaction, then a few other drugs become pertinent, and I need to add them and test them and watch the speed to recovery.

So, the first thing I added to her treatment was Promethazine. Now, Promethazine is a drug, an antihistamine, an old generation antihistamine that is used to treat severe allergic reactions. It is an essential drug, World Health Organisation approved, that every doctor should have in this emergency kit. So, when a patient comes in with the bee sting, a steroid and Promethazine are the drugs of choice. So, I added a dose of Promethazine to her treatment. To be cautious, I gave her a kiddie's dose of 10 milligrams – usually we use 25 milligrams three times a day, and adults to four times a day. I gave her a 10-milligram tablet and said, take it three times a day. It was just for one day, that particular day that she came in. And I told staff to please contact her tomorrow and look at speed to recovery – has it made a difference to her improvement?

And the very next day, when we contacted her, she was busy washing the dishes and she was perfectly fine. The breathlessness had gone completely, but I had given her a single dose and I expected a rebound. So, I advised her to please be cautious because I would expect the breathlessness to resurface if this is an allergy and we would have to suppress this for a little while. And of course, the very next day she was breathless again, and I reinstituted the antihistamine and she recovered promptly.

So it was at that point that I realised that I am dealing with a severe allergic trigger. And I added, now, with an allergic reaction you get the release of certain chemical mediators, Histamine, leukotrienes, prostaglandins and prostacyclins and platelet activating factor.

Now, the modality when you treat an allergic reaction is to use a high enough dose of steroid to turn off this inappropriate immune tap that has been turned on. The second thing you do is mop up all the mediators that have spilled already. And this is where timeousness is important. The longer you leave it, the more the mediators, the more the damage. And to mop up those mediators, histamine is addressed by antihistamines, leukotrienes by montelukast, platelet activated by either an anti-coagulant or Aspirin. Prostaglandins and prostacyclins are dual kind of mediators that are beneficial and so don't actually need to be addressed. So, I added montelukast and aspirin to my protocol very early on. And that has been the modality of my treatment.

I knew about the inflammation, the cytokine storm, the thrombotic events that were seen in patients. However, I was of the opinion that this was a hypersensitivity triggered by some sort of viral debris on the eighth day. And that hypersensitivity trigger, left unchecked, would lead to hyper-inflammation like we saw in hospital settings. And if that hyper-inflammation, leading to a cytokine storm, was not addressed appropriately, it would lead to thrombosis and so all the clots.

And that has been my modality of treatment through the pandemic.

The first thing with this kind of treatment that I found very strange was that the World Health Organisation had put out this recommendation that we should isolate patients for 14 days. That I found to be the most disastrous advice you could give anyone, especially if they were going to have a severe allergic reaction on the eighth day that couldn't be predicted. They needed to be told about this. And, like a bee sting, if you had a bee sting and came to me on the eighth day, and I said, "well, there's nothing I can do about this. You wait at home. And let's see what happens." By the time you realise that you are critically ill, you will have multi system organ damage. And then you would present yourself to hospital. And when you presented yourself to hospital, the doctor in hospital is unaware you were stung with the bee and he would have absolutely no idea where to start treating you. He would just be trying to keep you alive.

And so, I had remarkable recoveries from the start. I've had patients present to me with saturations of 70% and, on the first dose of treatment, had that 70% improved to 85% within an hour and an hour and a half. There's no other medication beside the antihistamine that has shown that speed to recovery. And because I managed to reverse the hypoxia so timeously in these patients, I didn't have the need for oxygen in my practice.

Now, I'm well aware of the so-called experts and peers that are out there dictating what we should do. And it's the reason I've been a controversial doctor all my life. I don't tend to follow the rules, I tend to follow the science, and that makes me controversial.

My staff noticed these remarkable improvements. They were well aware of the rural population dying at home and the mortality and morbidity of not getting treatment. We were also well aware of the patients dying in hospital. I was also well aware that remdesivir was being punted. I knew that remdesivir was toxic. I knew that it caused kidney failure, it caused cardiac issues. And I saw those things like the presenters before me alluded to. None of my patients got into any kidney problems. None of my patients got into any cardiac problems. And of course, on clinical examination of these patients, it was not to cope with pneumonia I was dealing with. It was not progressive. Patients were perfectly fine the day before. When they came to me breathless, they were not acutely ill, they were tired, they were breathless, but from afar they were perfectly fine. And when I examined them clinically, they had no preparations. They had none of the symptoms that you would associate with the pneumonia, but they did have breathlessness. So I was under the impression that I am dealing with a hypersensitivity trigger on the eighth day, in a subset of patients that are allergic to something in this virus, and that hypersensitivity was causing a hypersensitivity pneumonitis, which would develop at different speeds depending on your allergic propensity to the allergy. And so, I treated it as such.

And so, my staff spoke to me about writing an article and giving this out to other doctors. Now understanding that I had the suspicion from the start that we're dealing with a lab made virus. And of course, we were told that there's a bad coronavirus that jumps species to human beings. Now, the one thing that would change on a virus that would make it jump species to a different host, is its receptor. And spike protein being the receptor on this virus, spike protein was on my radar from the start as the possible allergen because it's new.

We've been exposed to coronavirus previously, and we've never seen this kind of pathology, allergy. And so, when you're exposed to a new environment, there might be something that you were never exposed to in that new environment that you might be allergic to. So, I was suspicious that spike protein, free spike protein, was the trigger on the eighth day causing these problems.

So, I published this article hoping to educate doctors – when I wrote the article, hoping to educate doctors and patients – and use this knowledge that I have found to save lives, and that is where the trouble started.

I shared the article with all the hospitals in my area before it was published. I made sure that every person that could have some impact on this pandemic was aware of what I had discovered. The hospitals were using antivirals. I found that absolutely illogical.

Now, I was of the opinion that the virus was gone by the fifth or sixth day. And so, I started looking at studies around the world, and there are no studies around the world that have managed to culture this virus past the seventh day. Yes, the PCR test remained positive for a month in some patients, but that's no indication of a live virus. So, I chose carefully what to believe. So, I looked at the data and I looked at culture results. And there were a lot of results showing culture positivity in the first seven days, and that tied into what I saw, people had a viral infection. But post seven days, there were very few,

if any, culture positive results in hospitalised patients. So, I knew that the virus had left. And that confirmed clearly to me that we were dealing with a separate pathology post eighth day.

So, I wrote this article, and I shared it freely with our Minister of Health here in South Africa, with the President of my country, with all the stakeholders that I could think of, with every doctor I knew. But I was very cautious because I was well aware – with the controversy around hydroxychloroquine, with the misinformation that was given to me about sanitation, isolation, PCR testing, masking, asymptomatic spread – that there was a bigger plan at play. So, I was very cautious about getting involved in the governmental regulatory structures. I didn't want what I had found to be suppressed.

So, I thought, well, I'll share it freely, But I'll share it amongst doctors and patients. And if I could teach doctors to treat Covid and make patients understand when to present, then I don't need anyone's permission to save lives. And so that is what I did. I passed it on to every journal I could think of to see who would be willing to publish it. The response from every journal – Nature, it was almost every journal in the world. My wife helped me with that submitting to every journal. The response I got from journals was either it was either that: we need copyright to your work; or, we only publish from our subscribers and I'm not a subscriber to all the medical journals. So, I thought, it's very strange, as the custodians of knowledge as journals claim to be, you cherry pick where you take that knowledge from.

So immediately I knew that I'm dealing with some sort of collusion – medical collusion. After all, I had found something that could save us from this pandemic and no one seemed to want to listen. I also shared it with my professor and principal at the university I studied at in India and my colleagues on that group. And I had an immediate response from them. My principal wrote back to me immediately thanking me for my work and so did my colleagues and so India knew about my discovery very early on in the pandemic, they understood my work with hydroxychloroquine, they understood the hypersensitivity trigger. I had also tried ivermectin. The reason I used ivermectin was because I was dealing with the pulmonary hypersensitivity and ivermectin is used to clear eosinophils from the lung, and that was the rationale behind me trying it and it worked. I mentioned that my colleagues in India and ivermectin became a thing there in the first wave. And so, India was the only country that held my hand through the first wave of this pandemic. I was completely ignored by the rest.

Then, in August that year, Modern Medicine and Academic Journal here in South Africa contacted me to publish my article. I had insisted that it gets published unabridged and unedited because it had some things in there that would be of great impact and influence on the pandemic seeing that we were dealing with a hypersensitivity reaction. That had some grave consequences and some implications for how we manage the pandemic.

One, in the first wave we saw people over 55 dying. Now remember, all the deaths in this pandemic comes from the second part of this illness, not the first and the second part is an allergic reaction. So I was of the opinion that people over 55 were actually exposed to some sort of coronavirus that was very similar to this before and they had developed the necessary antibodies. Now remember, if you are allergic to something, your first exposure does not cause illness, you need to be sensitised first so your second exposure onwards creates the problem. So I was of the opinion that people over 55 were sensitized and so they had a severe allergic reaction, or those that were allergic, and that's the reason we saw deaths above 55 years of age. However, those below 55 would be sensitised in the first wave and from the second wave on I expected that people below 55 would die. They would have the allergic reaction because they are now sensitised and we would see younger people die. And that was one of the gravest predictions of the article that I wrote.

The second was to understand risk. Who is actually at risk in this pandemic because we had shut off the entire planet indiscriminately, everyone had to stay home. But if we knew who was at risk then we could risk stratify more effectively. And to risk stratify we would need to find the specific IGE subtype for the allergen and see who is allergic. And those are the people at highest risk of having the second phase and of course at highest risk of mortality and morbidity. And so, my article covered all these different parts to this pandemic.

The one thing that made my article very controversial was that I expressed an opinion saying that if early treatment, like I have seen personally myself, if early treatment could curb all the mortality and morbidity of Covid illness, it would make a vaccine to a mutagenic RNA virus, rushed to market, wholly unnecessary. And I think that was all the controversy that my article then caused.

When we got into the second wave, I needed proof of my eighth day and I needed proof of what was happening. None of the local labs were willing to test patients with Covid. You would only get tertiary service if you were hospitalised. So, I had to rely on clinical improvement of my patients to make adjustments to their medication to get them to recover. And I managed to do this.

So, I contacted the local lab to say, look, I need assistance with this work – once it was published in Modern Medicine and Academic Journal – and the local lab then offered me their services, willing to give me a research grant to look further into

this. But being a commercial lab, they did not have the capacity to develop testing for a specific IGE subtype to see who is most at risk. I mean we can tell if you're allergic to milk by the same very same test. We can tell if you're allergic to eat by the very same test. This is not rocket science. All we need to do is understand what the allergen is and then see who's allergic to that particular allergen. So, I started to check IGE levels and started to do some blood testing as the second wave came by.

But in the first wave, one other thing I need to mention is all the patients that I've treated, some 800 of them. I never had a single long Covid case. So I was of the opinion that the mild cases resolve spontaneously, talking about people allergic and presenting on the eighth day. The moderate cases were not treated and those were the long Covid cases that were sitting with an untreated moderate long-term allergy. And of course, these very severe cases needed quick aggressive treatment and if not, were the ones that were ending up on the ventilator.

And of course, the diagnosis of pulmonary hypersensitivity rather than Covid pneumonia may put ventilation into a very poor light. Ventilation is absolutely the wrong way to treat a hypersensitivity in pneumonitis. So I was of the opinion that the world had misdiagnosed a pandemic, calling it a Covid pneumonia rather than a hypersensitivity pneumonitis. And all the mortality and morbidity resided in the second part, caused by an allergen, not the virus itself.

In the second wave, we had the South African variant. Now, just so I'll reiterate, later on, in the first wave, we had mostly black patients present to me. I had not a single Indian patient, not a single coloured [mixed race] patient, and not a single white patient in the first week. It was all black patients.

Now, I assumed that that would be because of their inability to isolate. They live in communities in close proximity, and I thought that was the reason I was seeing it spreading in that community. However, in the second wave, we had what we'd call the notorious South African variant. And looking at the genetics around that variant, the only thing that had really changed was the spike protein. The mutation caused a change in spike protein. And so, when we got the cases coming in, I needed again to look at the symptoms and the presentation, to understand what's going on.

And, of course, it was very strange that only the spike protein mutated, nothing else in the virus changed. And that's not how natural mutations occur. So, it reinforced my understanding that I'm dealing with the lab made virus here. And when you look at genetic manipulation, besides engineering a virus, you can also engineer the mutations that occur every so many cycles, so you can engineer the mutagenicity of a virus.

So, in the second wave, we had the South African variant with the new spike protein. Symptomatically, we had a more contagious virus. It spread very quickly in families and in communities. And, of course, that ties in with the change, in spike protein having a greater affinity for its host. Of course, the symptomatology changed – I was seeing a lot more gastrointestinal symptoms, I wasn't seeing the respiratory symptoms. Patients were presenting with a very mild sore throat that went away in a day. But they had runny tummies heartburn reflux, a lot of gastrointestinal symptoms. And that told me that the change in spike protein had given it an affinity for ACE receptors in the gut. Again, a change in spike protein, a change in affinity for receptor.

And then the eighth day remained the same. Patients, there were a subset of patients, who deteriorated on the eighth day, but that deterioration had changed. Now, those patients that deteriorated on the eighth day presented with gastrointestinal symptoms, a re-emergence of gastrointestinal symptoms. So, I knew that the eighth day was now an allergic reaction, again. But not an allergic reaction triggered in your lungs like the first wave had done, this allergic reaction was triggered in your gut. But with progress, would lead to hyperinflammation, would lead to coagulation, and would eventually lead to breathlessness.

So, I was again seeing breathlessness but no more on the eighth day. There was a worsening of symptoms, gastrointestinal symptoms on the eighth day, but the breathlessness took two or three days to develop and that is the progression of allergy. I treated those patients in very much the same way, catching them on the eighth day being quick and aggressive to treating them and all of them resolved.

But what this second wave drew to my attention, or confirmed, was my suspicion that spike protein was the culprit. Because on the eighth day in the second wave I was seeing far more severe allergic reactions that required far more aggressive intervention to curb it.

Now speed to recovery again was the measure of what I needed to do. The dose of steroids that worked in the first wave was taking far longer to curb this in the second wave and needed to be increased. The longer that tap stayed open the bigger the problem was going to be. And so, in the second wave I used a far higher dose of steroid but the rest of my treatment remained almost the same. And of course, that implicated spike protein.

Now this was at the end of 2020, during the second wave, and it was at the point where vaccines were going to be rolled out to the world. Now, at this point I had clarified that the primary pathogen of Covid illness was not coronavirus at all. Coronavirus was a vector – it caused a transient respiratory illness and our immunity was strong enough to deal with it. But once our immunity dealt with the virus, the debris left behind from this eighth day caused an allergic reaction in those that were sensitive to spike protein and so people that were allergic to spike protein would have this reaction. So, spike protein became the primary pathogen of Covid illness and spike protein was the reason for all the mortality and all the morbidity I had not a single patient demise in the first seven days of this illness.

So, spike protein now clearly was the pathogen I was dealing with. And of course, being a pathogen, it was causing allergy. Now the vaccines that were being developed at the time, messenger RNA vaccines, were all designed to get your body to make spike protein. Now spike protein being the primary pathogen of Covid illness, that was a dangerous game to be playing. We have many other parts of this virus that we could have chosen that were more stable, that could have been used to make a vaccine. For some reason spike protein was chosen.

So, I hoped that my work would draw attention to the danger of using spike protein to make a vaccine and so I brought this to people's attention. But again, I was ignored. So, I knew that there were some ulterior motives at play. And so, knowing that the vaccines will not be stopped, my research, understanding and push became about looking at spike protein, not being distracted by the virus and trying to understand what spike protein would do in the human body.

Now, remember, when you have a coronavirus infection and you're exposed to free spike protein on the eighth day, it is a stat dose of spike protein and it will only harm you if you are allergic to it – but if you're not, your body will clear it away. But if you are given a vaccine that gets your body to make spike protein, now you will be exposed to spike protein for a prolonged period. And so, spike protein does not only now have an allergenic potential, it will now have a biological effect on your body.

To put that into perspective: a drug like penicillin, its biological effect on your body is that it's an antibiotic. But for it to have that biologic effect, you need to take the full course. Now, if I had to give every person on this planet a single dose of penicillin, it will not have that biologic effect of an antibody antibiotic. But if I gave every single person on this planet a single dose of penicillin and then I denied them medical care for 14 days, every person that was severely allergic to penicillin would die of an allergic reaction. And that's what happened with Covid infection. People were denied treatment to a simple allergic reaction.

But, with the vaccine and being exposed to spike protein for a prolonged period, like being exposed to penicillin for a prolonged period, it starts to act as an antibiotic. So, I needed to understand what a prolonged exposure to spike protein would do to the human body. And that has been the focus of my research and understanding ever since spike protein got implicated.

In the third wave, we had very much the same happened again. We found that patients presented it with symptoms. Again, gastroenteritis was gone. We had patients coming in with sore throats again. The symptoms had changed and of course, the spike protein had changed. On the eighth day, patients were not breathless, patients were not having gastroenteritis, but they presented with an overwhelming sudden onset of fatigue. And so, I started to advise patients about that symptom on the eighth day. And if it occurred to present timeously.

We saw that the allergic reaction in the third wave seemed to affect the vessels more than anything else. And patients were developing clots, emboli, and that seemed to be the trigger here. So, it seemed like we were again having an allergic reaction on the eighth day, but the allergic reaction was focused on the circulatory system. And so again, the same treatment was instituted with the same results. Every patient that came in on the eighth day with an overwhelming sense of fatigue was started on the treatment protocol for a severe allergic reaction. And they all timeously improved.

And all this got confirmed, now, that I had access to laboratory findings by measuring Interleukin 6 values, CRPs and d-dimers. And I could clearly show the exponential rise in these values from the eighth day for those patients who had symptoms. And I could clearly show the turnaround back to normal once I had treated them. And the turnaround was timeous, again. I had every patient of mine almost completely recovered, irrespective of how severely they presented to me post eighth day, within a week. I've had patients present to me with saturation of 40% on oxygen, brought to me with an ambulance on a drip. And in a week, I had them on home treatment, at 98% saturation on room air. And the timeous reversal of the hypoxia negated the need for any supplementary oxygen. So, in the third wave, I realised the change in spike protein changed the system that was being affected by the allergy.

And of course, I noticed something else unusual. In the second wave, it was mostly patients of Indian descent that came and saw me. There were no black patients anymore in the second wave. It was all patients of Indian descent. And then in the third wave, it was very few patients that were black or of Indian descent. And it was mostly the white population and the

Muslim population that was affected in that wave. And I thought that to be very strange because I had assumed that it was the black population in the first wave because of their social circumstance.

Then I looked at the world around me and I found exactly the same happened in America. The first wave affected the African American population more than anyone else. The second wave ravaged India, and I had more Indian patients see me here in South Africa. And then in the third wave, it affected the Caucasian population globally and the Muslim population globally.

So that drew my attention to something far more sinister. I knew that I was dealing with an engineered virus. I assumed that it was a lab leak. But I also had at the back of my mind the understanding that this might have been pre-planned. And if you had a virus, with different variants that seemed to affect different systems, a propensity for different systems – respiratory in the first variant, gastrointestinal in the second and circulatory in the third – and had a propensity for certain ethnicity, that's a very bad omen. Because if this was pre-planned, then it's a preamble to ethnic cleansing. It's an understanding of how to affect different systems and how to affect different population groups with the mutations that you engineer into a virus. And so, I knew at that point that I'm probably dealing with the bioweapon.

And so, my research has all been in that direction. I've pushed researchers to stop looking at the virus and to start looking at spike protein. And we needed to understand what the spike protein was doing, because I knew that Pfizer, and the likes, were going to expose the entire planet to this biologic agent called spike protein.

And so, we started looking at long Covid. We started looking at vaccine injuries. Now with long Covid, when I started seeing patients with long Covid, I started testing IGE levels to try and prove that I'm dealing with the hypersensitivity and every single one of them had elevated levels. And that confirmed for me that we're dealing with hypersensitivity.

Subsequently, Kenneth Dear and Marcus Sanchez published an article about the lethality of Covid illness, speculating that the lethality was caused by hypersensitivity pneumonitis, not a Covid with pneumonia. And I proved that clinically.

Recently, an article was published from China that looked at the use of steroids, but also looked at the specific IGE subtype for spike protein. Means, what I wanted to do, to look for those that are allergic to spike protein. And they found a direct correlation between severity of illness and IGE specific to spike protein levels, which proved conclusively that on that eighth day we were dealing with a hypersensitivity trigger. There was an allergic reaction which was being left unchecked, and it was causing all the death we see and all the damage we see.

Now, from long Covid and from the understanding of vaccine side effects, researchers have looked into the structure of spike protein and what its long-term effect on the human body would be. We know that it causes endothelial injury and will damage your blood vessels. And if it damages those blood vessels, it would cause clotting in various areas of the body. And those people that are predisposed to vessel damage – like your diabetics, your hypertensive – are most in danger of having this damage become clinically significant.

The second thing we noticed is that it causes an immune mediated damage to the myocardium in the heart. And so, we've seen the myocarditis in young children. We've seen the clots. We've noticed these things with the vaccine.

The other thing that was discovered was that the vaccine, the spike protein, has similarities to other pathogenic proteins that we know of. One of them being the proteins made during HIV illness that actually causes immunosuppression. Now, if the spike protein caused immunosuppression, then we would expect to see a re-emergence of latent infections like Epstein-Barr, like herpes zoster. We'd expect to see a re-emergence of cancers that were in remission. And we would expect to see a waning of immunity over time and people exposed to spike protein becoming more prone to illness. And we've seen that with the vaccines, and we've seen that with Covid. We've seen people that are vaccinated actually being more prone to developing severe illness.

Now, the claim from the vaccine manufacturers that the vaccines prevent severe illness, and yet I find that amazing that they could make that claim. They've refused to accept my work on the pathogenesis of Covid illness. I think simply because I have proven that spike protein is the primary pathogen. And if you accept that spike protein is the primary pathogen, that shows the vaccines in a very dangerous light.

Now, if you don't accept what causes severe illness and death, how can you claim that your product can prevent it?

So, they have absolutely no pathologic evidence or pathophysiologic evidence of the working of the vaccine. We know that it's not a vaccine because it doesn't prevent infection and transmission. Now, it exposes you to spike protein. So clearly, if you're allergic to spike protein, the vaccine works as a desensitisation tool.

So, we do desensitisation for patients that are allergic to certain allergens. We expose them to mild doses of those allergens and then they become more tolerant.

So, the vaccine is giving people that are prone to severe illness and deaths, by exposure to spiked protein which is the allergen, a little bit of tolerance for a limited period of time. And once that vaccine stops making spike protein, you become intolerant to Covid again and it no more has the ability to prevent severe illness and death. And we've seen that globally.

Then again, as well, with spike protein it is a membrane protein. And we've seen with the Japanese studies that it circulates throughout the body. Now, every tissue that is exposed to spike protein and starts to make spike protein will express it on its surface. It will be recognised as foreign and that will trigger a host of autoimmune conditions, which we've seen as well.

We've also seen that spike protein crosses the nucleus into the nucleus of the cell. It inhibits the [bracket] protein, which is used to repair double standard DNA breaks. And so, it will impact on your DNA's ability to repair itself. And that would cause an explosion in cancers. Because cells that actually remain viable after DNA damage are most likely to become cancerous.

And all this bears out with long Covid and the vaccine adverse side effects that we've seen. The increase in all-cause mortality that we've noticed globally since the vaccine. And if you look at the trend in that all-cause mortality, it is exactly what we predicted the vaccine would do. We're seeing the neuropathies, we're seeing the blood clots, we're seeing the myocarditis, we're seeing the emergence of latent infections, we see the re-emergence of cancers, we've seen Alzheimer's, dementia, neuropathies. We are seeing all these things.

Now, when we come to omicron, Omicron started here in South Africa and immediately everyone shut their borders. I thought that was absolutely unnecessary. It was almost a vaccine that we could use as a mild attenuated vaccine. But I was also suspicious that omicron, with all the changes we saw in it, might be a new engineered vaccine virus. Because now suddenly we had 30 new mutations in the spike protein. And like the previous guests have alluded to, that is not natural.

So, I had it at the back of my mind that this might be the Christmas present we all wanted, but there might be a sting in its tail. And so, I watched omicron very carefully. The only system that was not affected by Covid infection was the neurologic system. But we saw the neuropathy in the vaccine side effects. So, I knew that spike protein had the potential to injure your nerves. And so, I looked at omicron in that light and with Omicron, it became clearly evident that it was neurotoxic.

A lot of the patients that I've seen have presented with neuropathy burning of their hands and feet, strain sensations around their body, migraine like headaches, pain radiating from their neck. It seemed to affect C6/7, brachial plexus kind of neuropathy. It seemed to affect T10 and 11 in your spine, which affects the diaphragm. And people had strained symptoms.

Yes?

Dexter L-J. Ryneveldt: Thank you so much for giving all that information and being so elaborative. I'm actually also looking that we still have a few questions.

Chetty: Yes, I'm actually done. That was the last omicron is where it all ended and where we are.

Dexter L-J. Ryneveldt: Okay, awesome. But if you are actually about to wrap up as well, also therapeutic trials, that's basically what you were talking about. Modality treatment and hypersensitivity. You have covered everything in relation to those three pointers?

Chetty: Yes.

Dexter L-J. Ryneveldt: Okay. So, what I want to ask you is that I have now, even the jury and the citizens of the world has seen, that when it comes to SARS-CoV-2 it is not a death sentence. Without a shadow of a doubt, it can be treated. And you have very brilliantly set out as well, also, your treatment plan. So, my question to you – what is currently happening all over the world in each and every country – will you agree with me that the government is actually practicing medicine on the population and as a consequence of that, they are actually standing in the way of doctors like yourself to give suitable life-saving treatments? Will you agree with this statement, sir?

Chetty: I will agree with it completely. Doctors are not left to make the decisions they are trained to make and they are being made by people that are wholly untrained.

Dexter L-J. Ryneveldt: So, yes – it is in agreement that the government needs to step aside and they need to trust in the medical doctors. Can you and also at the same time, tell us what is your success rate, percentage wise?

Chetty: I've been through over 10,000 patients that I've seen myself, physically myself. I have not had a single death. I have not hospitalised a single patient, and I have not put a single patient on oxygen. There were four deaths in my practice, but four deaths were because of an overabundance of caution by family members who wanted those patients hospitalised. When those patients were put in hospital, the doctors there refused to collaborate with me. My treatment was stopped. They were put onto hospital protocols, and those were the only four deaths that I've had in my practice.

Dexter L-J. Ryneveldt: So, will you then say when it comes to your treatment plan, you've got 100% success rate?

Chetty: I would say that without a shadow of doubt. And I have doctors around the world that are trained with the same protocol and I've had exactly the same success

Dexter L-J. Ryneveldt: Thank you so much, doctor.

Reiner Fuellmich: Yes. Thank you very much, Shankara, this is the good news at the end of the day, so to speak.

Chetty: I hope it throws light on what's transpiring around us and the plan around on us that is more meets the eye.

Reiner Fuellmich: I agree.

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